STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G079	A. BUILDING _____ B. WING _____	R-C 12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-NORTH WILLOW	2002 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This visit was for a post-certification revisit (PCR) survey to the PCR to the PCR to the PCR to the investigation of complaints #IN00082450 and #IN00082518 completed on 10/4/11. This visit was in conjunction with a PCR to the investigation of complaints #IN00098167 and #IN00098684 completed on 11/9/11. This visit was in conjunction with a PCR to the PCR to the predetermined full recertification and state licensure survey and to the PCR to the PCR to the investigation of complaint #IN00094073 completed on 10/4/11. This visit was in conjunction with a PCR to the PCR to the PCR to the investigation of complaint #IN00086569 completed on 10/4/11. This visit was in conjunction with a PCR to the investigation of complaint #IN00095883 completed on 9/15/11. Unrelated deficiency -Corrected. Dates of Survey: 12/12, 12/13 and 12/14/11 Facility Number: 000622 Provider Number: 15G079 Aim Number: 100272170 Surveyors: Paula Chika, Medical Surveyor III-Team Leader Mark Ficklin, Medical Surveyor III Steven Schwing, Medical Surveyor III Keith Briner, Medical Surveyor III	{W 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G079	A. BUILDING _____ B. WING _____	R-C 12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-NORTH WILLOW	2002 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	Continued From page 1 Golden Living Center-North Willow was found to be in compliance with 42 CFR Part 483, Subpart I and 410 IAC 16.2 in regard to the PCR to the PCR to the PCR to the PCR to the investigation of complaints #IN00082450 and #IN00082518. Quality Review completed 12/16/11 by Ruth Shackelford, Medical Surveyor III.	{W 000}		